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ABSTRACT

This paper describes a nurse practitioner directed health center education program for senior citizens in Medford, Massachusetts. The planning process, including needs and location decisions, is defined, and a summary of needs survey data on the population is offered, including health problems (medication problems, lack of exercise, depression, and sleep difficulties), and subjects of interest to potential program participants (general health information, taking medication safely, normal patterns of aging, the body and how it works). The theoretical framework for program direction, incorporating biophysical, psychosocial, and socioeconomic needs, is described, and the educational framework of the program is presented. An accompanying case example from the normal patterns of aging component, focusing on common skin changes, is included. Outreach interventions and monthly community programs are highlighted, focusing on techniques to overcome initial negative reactions to the program. The overall program design concept, as a continuity model contrasted with a variety model, is discussed with an emphasis on the benefits of the continuity model, e.g., familiarity, flexibility, ongoing support. The paper concludes with an evaluation of the health education program and conclusions about its effectiveness. A monthly calendar of program topics, and a listing of health screenings, along with the number of attendees for each, is appended. (BL)

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THE DEVELOPMENT OF AN INNOVATIVE HEALTH EDUCATIONAL PROGRAM FOR THE WELL ELDERLY

by

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Abstract

Prior studies have cited health as a major elder concern and identified the need to develop consumer education programs in this area. This paper examines the development and impact of such a program creatively designed to address the educational needs of the well elderly, coupled with the provision for gerontologic health services. The key aspect of the process featured the utilization of a Gerontologic Nurse Practitioner (GNP) who, acting as both educator and health provider, became identified in the community as an accessible professional resource.

The health education methodology included group classes, self-help groups and community outreach events, guided by the curriculum plan which utilized concepts of aging adaptation, and consumerism. The program design coordinated individual assessment and resolution of health concerns resulting from the community education and screening programs.

Background

Prior reports have cited health as a major elder concern and document the need to develop relative educational programs (Alford 1982, Campbell 1981, German 1978). This paper examines the impact of such programming designed to address the health educational needs of the older adult, coupled with the provision for gerontologic primary care services.

In 1981 a nurse practitioner-directed health center for senior citizens opened in an elderly housing complex in Medford, Massachusetts. The center was established as a satellite of the Lawrence Memorial Hospital of Medford, a local community hospital, in response to the increasing aging population. The philosophy of the center evolved from its nursing origins. It emphasized "augmentation of the older adults' resources and support systems with the capitalization of one's strengths and problem-solving skills in order that each person attain the highest level of wellness possible."

This philosophy influenced the development of the center's services by expanding the scope of practice beyond the traditional primary care focus into the realm of community health education and consumer advocacy. In this framework the emphasis on health education, health promotion, and disease prevention took place.

The GNP director initially budgeted 50% of her time for the health education program and 50% for the health center's primary care, consulting and administrative services. This paper specifically addresses the educational aspect; further information is available regarding the senior citizens health center (Mahoney 1983).

Planning Process

A survey of the existing elderly community resources revealed sporadic health programming of a very limited nature. However, six locations were identified in the community as elderly clustering sites with approximately 20-25 elders at any given time. Attention focused on these sites to evaluate the layout, acoustics, lighting, and amplification options, in view of the hearing/visual deficits common in the elderly. Three meal site locations were used due to their geographic distribution and clustering time. One of the three was in an elderly high rise apartment, the other two in small drop-in centers. The city's oldest and newest subsidized elderly housing became the 4th and 5th sites and number 6 was a community club which closed after the building was sold during this year.

It was the belief of the director that programming in the community would reach elders who otherwise would not attend due to the planning required to obtain transportation, arrange scheduling, etc. The goal was to minimize the barriers and increase the enabling capacity of the participants. Interviews performed at these locations identified the characteristics of those participants, and their potential interest in health programming. A self-designed survey tool was administered which identified current health habits, existing health risk behaviors, health topics of interest and programming details.

Survey Summary

The population (n = 82) was a non-randomized convenient sampling of 87 people. Eighty-two participated, 20 males and 62 females. Mean age was 74, with the highest percentage (22) being between the ages of 81-90. Fifty percent lived in senior housing, 37% lived in their own home, 12% private apt./room. Twenty-seven % walked to the site, twenty-four % used the Senior Van with an equal number driving themselves.

The Top 4 Health Problems uncovered by the survey were:

1. Potential medication problems-65%
2. Lack of exercise 44%
3. Depression 33%
4. Sleep difficulties 27%

The Program section revealed the Top 4 Subjects of Interest to be:

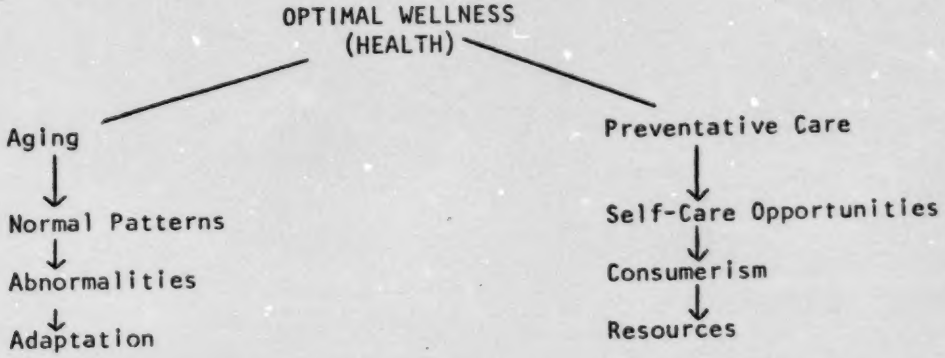
1. General Health Information
2. Taking Medications Safely
3. Normal Patterns of Aging
4. Your Body and How It Works

The best time for the program according to the survey was in the afternoon, one hour in length, one session at a regular meeting or congregate meal.

In planning the programs, input from the elderly was incorporated. The sessions followed the survey suggestions, four of the programs after the congregate meals and two at a regular meeting at the particular site.

Theoretical Framework

A theoretical framework was established to provide overall program direction with the major component of the program being optimal wellness (health). The holistic viewpoint of the aging person incorporates multifactorial components of the biophysical, psychosocial, and socio-economic needs in reaching a harmony equalling health. Further development highlighted the subconcepts of aging and preventative health care, and through these flowed others highlighted in the accompanying chart.



Educational Framework

For each program the Core components consisted of:

The normal patterns of aging

Your body and how it works

General preventative health care measures

You as a consumer

By establishing a core, it enabled the elders' identified area of desired knowledge to be incorporated into each program, providing continuity, a foundation to build on, and an aid to learning.

Several screenings were coordinated with the outreach programming. The GNP then could not only publicize the screening, but inform the elders of the risk group particularly in need of the screening. A minimum of 20% positive findings resulted on an average, well above predicted expectations.

Case Example: The June Program - "Sense in the Sun"

The body part it focused on was the skin, and its purposes in body functioning. Normal patterns of aging included common skin changes related to the aging process and abnormal changes due to solar and environmental exposure. Prevention focused on how to recognize health hazards, and existing community resources to assist in this process. Self-health responsibility centered on preventative health care measures regarding clothing, exposure time, general skin observations. Consumerism was brought out in using suntan, sunscreens, and wrinkle creams.

The teaching methodology followed a didactic format plus the American Cancer Society's related skin cancer film. Reinforcement was accomplished by the accompanying pamphlets distributed to each attendee as well as skin care samples. A skin cancer screening was held at the Senior Citizens Health Center at the end of the month with 9 referrals (31%) for biopsy follow-up visits.

A unique component of this program featured the utilization of the GNP who as both health educator and provider could address the immediate elder health concerns. One attendee came to the skin program because of a recent onset of an itchy rash and wondered if this was due to the dryness of her new apartment. A brief assessment suggested a drug reaction, and she was

instructed to immediately contact her physician. She admitted she would normally not bother the physician and would have put up with the itching longer. Upon follow-up her medication had been changed and she still expressed amazement that her prescription medication had caused the problem.

Mrs. M. deeply concerned about a "mole" had watched it for 3 years fearing malignancy. After the skin program, she showed it to the GNP and was greatly relieved to learn that it was a benign skin tag, a normal variant of skin aging. However, two other attendees were noted to have suspicious facial lesions and were booked for the skin cancer screening.

Outreach Interventions

Senior citizens vary in their level of community awareness. Coupled with individual hesitancy to participate in unfamiliar events, these factors can negatively effect initial programming response. The adage "you can't teach an old dog new tricks" represented some older adult as well as professional responses to this program's initial designs.

Strategies to overcome these negative factors included linking with the hospital's public relations department to stimulate awareness through a coordinated publicity campaign. The fact that the educational programming came out of a senior health center located in the community provided permanent visibility. Initial publicity efforts focused on the center's opening, the staff, and services offered. Monitoring utilization patterns, it was determined that the local community newspaper and local elder newsletter reached the most older adults. Monthly releases placed in both identified the health topic, site locations, and related screenings through the center. A quarterly fluorescent flyer identified the seasonal programming and it was distributed throughout the community. Ongoing publicity reminders of programs became a vital program component.

Outreach events capitalized on community activities to attempt to reach the older adults who did not utilize the gathering sites. At a local health fair I designed a "wheel of health" to attract elder interest. Participants spun the wheel and won prizes of free preventive health care. Entitlements to free blood pressure checks, anemia, urine, etc. testing at the center were "won". Free health educational materials were distributed to all players. This non-threatening fun approach attracted

the interest of the elders and initiated discussions with the nurse practitioner. Several referrals for follow-up care with the GNP and/or community resources were made resulting from this event.

On Thursdays during nutrition month (May), the GNP rode the Elder Mobile Market which serviced highly elder-populated, residential areas.

The objective of this program was to introduce this population to economic, new healthful food experiences and exposing them to the GNP. One week home made bran cookies were served, another week high potassium low calorie fruit drinks, tofu dip with fresh vegetables and lastly, low fat yogurt/banana salad. The free food samples attracted participation, the atmosphere promoted discussion of dietary concerns. Being on the van, the nurse was able to teach the elders how to shop and still maintain dietary restrictions. The market manager cooperated by changing several of the product lines to less salty, more nutritional products.

Monitoring the 50 participants who stated that this was their first yogurt experience, 35 verbally said they liked it and would purchase it sometime. The manager agreed to carry yogurt during the following month to see if the elders would purchase it. The month's review demonstrated the product was sold out each week and it then became a staple item offering.

Monthly Community Programs

Every location had the same core program, but slight planned variations were included to make it more appropriate to the particular setting and personal characteristics of its participants. Each site evolved its own group personality resulting from the audience variables, ie. hearing deficits, visual deficits, attention span, level of education, and ethnic group.

The subject material for the presentations came directly from participant input via the initial and ongoing surveys of subject interest. Primary objectives were formulated relative to each program whereas the secondary objectives of professional accessibility, triage, and referral remained throughout. The methodology utilized sensory stimuli and variant repetition to assist in processing the new information. Participants saw and heard the presentation, touched the samples, and kept the handouts for reinforcement. To promote stimulation the program format varied role playing, didactic lecture, discussion questionnaires, and audio-visuals. In

each situation group discussion was incorporated to assess the participants perceptions and clarify misinformation. The latter proved particularly important since the discussions and inaccuracies uncovered many distortions in health care beliefs.

Continuity Model

The program design followed what I labeled as the continuity model. In this format one key person functions as the stabilizing coordinating element. The opposite extreme in programming presents a variety of episodic one-time guest lecturers. The benefits of the continuity model versus the concerns of the variety model are noted in the following outline:

Continuity Model Benefits	Variety Model Concerns
develops repoire, knows audience	- fast pacing, loosing audience
same routine - elders "set" to learn	- talking above audiences' comprehension
familiar with sensory & site problems	- arriving late
facilitates elder input, discussions	- unaware of sensory perceptual problems
flexible response to audiences' needs	- minimal time for discussion
monitors response to referrals & provides ongoing support	- questions limited to specialty area
	- no follow-up opportunity

To maximize the continuity benefits the majority of programming utilized the GNP the first year. However, several guest lecturers participated for variety and their specific area of expertise eg. F.D.A. consumer agent on quackery. To minimize the variety model concerns, a planning session with the GNP familiarized them with the group personality and needs specific to the sites. The GNP attended each session to provide for continuity and responded to questions/concerns outside the guest presenter's field, and identified local resources.

Evaluation

The evaluation component of this program proved to be a particular challenge. A pre and post test for a 4-part hypertension series was disastrous. Attendees didn't see the need to take the same test again, or changed their answers to the opposite one figuring the first must have been wrong to repeat the test. Despite my explanations and assurances, this population averaging a 5th grade education was not familiar or secure with formal measurements.

A very basic form in large well-spaced print, with simple wording, all on one page proved to work best for routine administration after each program. Elders consistently rated the programs highly. Six months into the program a composite survey was performed. To the question "How would you rate the quality of the program?" (n = 193), 173, (90%), rated it excellent, 20 (10%) good. "Did you learn any new information?" (n = 237), 199 (84%) said they learned a great deal, 38 (16%) a good amount and no one checked fair or no new information learned. "Do you wish the programs to continue here?" noted a 100% unanimous yes vote. Many wrote positive comments on their forms noting appreciation for the outreach efforts.

Informal evaluation observations monitored behavioral change. When one of the club sites closed several members crossed town to another site for the programs. By 9 months into the program elders began to set up chairs in anticipation and hold off card playing activities! Follow-up phone calls at the center indicated information application. Likewise, attendance at the screenings and follow through on recommendations demonstrated positive health seeking behaviors.

After teaching session one of How to Take Your Own Blood Pressure, the local pharmacy was sold out of kits. Another time several generic, over-the-counter products suggested during the skin care talk likewise were sold. A year after the Winter Skin Care Program an elder stopped on the street to proudly tell me that during arts and crafts that morning one of the participants complained of itchy dry skin. She repeated the recommendations on how to bathe, best skin moisturizers and barriers, soap cautions, and tricks to prevent itching. The group wanted to know how she got so smart. She said I told them "they could get smart too, go listen and talk to the Nurse Practitioner."

Statistics

Health Education Programs

		Attendees
February 1981	Hypothermia & Winter Skin Problems	143
March	Taking Medications Safely	132
April	Preventive Health Care - Why Bother?	110
May	Nutrition and You	108
June	Sense in the Sun/Summer Skin Problems (Skin Cancer Screening)	267
August	How to Take Your Own Blood Pressure (4-part self-care series)	26
September	Fall Flu Prevention (vaccine program)	71
October	Dental Health in the Later Years	88
	Weight Loss Group (total cancer screening)	16
November	Oh My Aching Joints	98
	Hypertension & You	80
	Myths of Aging	80
December	Stress Management for Seniors	95
January 1982	Hypertension - 4-part mini series	107
	Hypothermia (plus hypertension screening)	80
February	Step Up To Foot Care (plus foot screening)	91
March	Safety for Seniors	67
April	Consumer Beware: Health Quackery	77
	Mobile Market Nutrition Outreach Program	147
May	The Fitness Challenge in the Later Years	76
	Fitness Group	64
		2,023 TOTAL

Health Screenings

Skin
Hearing
Oral/Dental
Foot
Hypertension
Respiratory

Total 660

Conclusion

From analyzing the problems that the Gerontological Nurse Practitioner assisted the elders to solve, it became apparent that this cohort of elders lacked awareness of consumerism in health care. "Studies indicate increasing activity in primary and secondary prevention, whereas tertiary prevention has been neglected. It is the outreach principle of consumer health education that must be improved upon to enable individuals to maintain a state of wellness following the diagnosis of disease or of risk factors that may contribute to disease." (Consumer Health Education, 1980, p. 20)

The senior citizen health education program through its unique design, effectively outreached into the community. Introducing an active health consumer role, to an elderly population used to passive methods of health care, required realistic planning. Sensitivity was needed toward participants as individuals with varying abilities and levels of self-esteem. Health education for the elderly carries its own particular challenges. These challenges were met through the utilization of a gerontological nurse as pivotal coordinator of elder education, service delivery and community resources.

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